CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 725

Department of Health & Human Services

Center for Medicare & Medicaid Services

Date: OCTOBER 21, 2005

Change Request 4108

SUBJECT: New ICD-9-CM Code for Beneficiaries with Chronic Kidney Disease

I. SUMMARY OF CHANGES: Renal dialysis facilities and hospitals should be made aware that the ICD-9-CM code 585 for Chronic Renal Failure will no longer be acceptable without the fourth digit extension for claims with dates of service on or after October 1, 2005.

NEW/REVISED MATERIAL
EFFECTIVE DATE: October 01, 2005
IMPLEMENTATION DATE: April 03, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	8 / 50 / 50.3 Required Information for In-Facility Claims Under the Composite Rate

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 725	Date: October 21, 2005	Change Request 4108

SUBJECT: New ICD-9-CM Codes for Chronic Kidney Disease

I. GENERAL INFORMATION

A. Background: The annual ICD-9-CM coding update effective on October 1, 2005 expands the diagnosis code of 585 for chronic kidney disease to include a fourth digit to allow for a higher degree of specificity in reporting the stage of kidney disease. The new codes for chronic kidney disease are defined as follows:

585.1 Chronic kidney disease, Stage I
585.2 Chronic kidney disease, Stage II (mild)
585.3 Chronic kidney disease, Stage III (moderate)
585.4 Chronic kidney disease, Stage IV (severe)
585.5 Chronic kidney disease, Stage V
585.6 End stage renal disease
585.9 Chronic kidney disease, unspecified

The necessary Medicare shared systems updates for the acceptance of the new codes are being made under a separate instruction, Transmittal 591, Change Request 3888, issued on June 24, 2005.

B. Policy: Renal dialysis facilities and hospitals should be made aware that the ICD-9-CM code 585 for Chronic Renal Failure will no longer be acceptable without the fourth digit extension for claims with dates of service on or after October 1, 2005. Renal dialysis facilities should report a diagnosis code of 585.6 for submission of claims with bill type 72x.

Billing for Epoetin Alfa (EPO) with HCPCS code Q4055 and Darbepoetin Alfa (Aranesp) with HCPCS code Q4054 must have the diagnosis code of 585.6. Epoetin Alfa (EPO) billed with HCPCS code Q0136 and Darbepoetin Alfa (Aranesp) billed with HCPCS code Q0137 are not appropriate for beneficiaries that have been diagnosed with end stage renal disease and therefore, should not be billed in conjunction with the diagnosis code of 585.6.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)					
		F I	R H H	C a r	D M E	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	
4108.1	Medicare systems shall install an edit for claims containing Q0136 when submitted with a diagnosis code 585.6.					x				
4108.1.1	Medicare contractors shall return to provider claims containing Q0136 with diagnosis code 585.6.	x								
4108.2	Medicare systems shall install an edit for claims containing Q0137 when submitted with diagnosis code 585.6.					x				
4108.2.1	Medicare contractors shall return to provider claims containing Q0137 with diagnosis code 585.6.	x								

III. PROVIDER EDUCATION

Requirement Number	**Requirements**	**Responsibility ("X" indicates the columns that apply)**								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4108.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn	x								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2005 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Institutional Billing: Wendy Tucker, Wendy.Tucker@cms.hhs.gov, 410-786-3004 or Jason Kerr, Jason.Kerr@cms.hhs.gov 410-786-2123.	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

`50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate

(Rev. 725, Issued: 10-21-05; Effective Date: 10-01-05; Implementation Date: 04-03-06)

Form Locator (FL) 4 - Type of Bill Code Structure

Acceptable codes for Medicare are:

721 - Admit Through Discharge Claim - This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer.

722 - Interim - First Claim - This code is used for the first of an expected series of payment bills for the same course of treatment.

723 - Interim - Continuing Claim - This code is used when a payment bill for the same course of treatment is submitted and further bills are expected to be submitted later.

724 - Interim - Last Claim - This code is used for a payment bill which is the last of a series for this course of treatment. The “Through” date of this bill (FL 6) is the discharge date for this course of treatment.

727 - Replacement of Prior Claim - This code is used when the provider wants to correct (other than late charges) a previously submitted bill. The previously submitted bill needs to be resubmitted in its entirety, changing only the items that need correction. This is the code used for the corrected or “new” bill.

728 - Void/Cancel of a Prior Claim - This code indicates this bill is a cancel-only adjustment of an incorrect bill previously submitted. Cancel-only adjustments should be used only in cases of incorrect provider identification numbers, incorrect HICNs, duplicate payments and some OIG recoveries. For incorrect provider numbers or HICNs, a corrected bill is also submitted using a code 721.

FL 6 - Statement Covers Period (From-Through) - Hospital-based and independent renal dialysis facilities:

Show the dates during which the patient’s care was under the supervision of the facility. Exclude dates when the patient’s care was under the supervision of another entity (e.g., hospital, another ESRD facility, SNF).

FLs 24, 25, 26, 27, 28, 29 and 30 - Condition Codes

Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

Condition Code Structure (only codes affecting Medicare payment/processing are shown).

02 - Condition is Employment Related - Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.

04 - Patient is HMO Enrollee - Providers enter this code to indicate the patient is a member of an HMO.

59 – Non-Primary ESRD Facility – Providers enter this code to indicate that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility.

73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.

74 – Home – Providers enter this code to indicate the billing is for a patient who received dialysis services at home.

76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

80 – Home Dialysis-Nursing Facility – Home dialysis furnished in a SNF or Nursing Facility.

FLs 32, 33, 34 and 35 - Occurrence Codes and Dates

Codes(s) and associated date(s) defining specific events(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved.

Fields 32A-35A must be completed before fields 32B-35B are used.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

24 - Date Insurance Denied - Code indicates the date of receipt of a denial of coverage by a higher priority payer.

33 - First Day of Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP - Code indicates the first day of the Medicare coordination period during which Medicare benefits are payable under an EGHP. This is required only for ESRD beneficiaries.

FL 36 - Occurrence Span Code and Dates

Code(s) and associated beginning and ending dates(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

74 - Noncovered Level of Care - This code is used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period.

FL 37 – Internal Control Number (ICN) Document Control Number (DCN) Required for all provider types on adjustment requests. (Bill Type/FL=XX7). All providers requesting an adjustment to a previous processed claim insert the ICN/DCN of the claims to be adjusted. Payer A's ICN/DCN should be shown for line A of FL 37.

FLs 39, 40, and 41 - Value Codes and Amounts

Code(s) and related dollar amount(s) identify monetary data that are necessary for the processing of this claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed, except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, show the codes in ascending alphanumeric sequence. There are four lines of data, line "A "through line "B." FLs 39A through 41A are used before FLs 39B through 41B (i.e., the first line is used up before the second line is used and so on).

Value Code Structure (Only codes used to bill Medicare are shown.):

06 - Medicare Blood Deductible - Code indicates the amount the patient paid for un-replaced deductible blood.

13 - ESRD Beneficiary in the 30- Month Coordination Period With an EGHP - Code indicates that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim.

37 - Pints of Blood Furnished - Code indicates the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible. Hospital-based and independent renal facilities must complete this item.

38 - Blood Deductible Pints - Code indicates the number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. Hospital-based and independent renal facilities must complete this item.

39 - Pints of Blood Replaced - Code indicates the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for un-replaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039x revenue code series, Blood Administration. Hospital-based and independent renal facilities must complete this item.

44 - Amount Provider Agreed To Accept From Primary Payer When This Amount is Less Than Charges But Higher than Payment Received - Code indicates the amount

shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.

47 - Any Liability Insurance - Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

48 - Hemoglobin Reading - Code indicates the hemoglobin reading taken before the last administration of Erythropoietin (EPO) during this billing cycle. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit.

Effective January 1, 2006 the definition of value code 48 is changed to indicate the patient's most recent hemoglobin reading taken before the start of the billing period.

49 - Hematocrit Reading - Code indicates the hematocrit reading taken before the last administration of EPO during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

Effective January 1, 2006 the definition of value code 49 is changed to indicate the patient's most recent hematocrit reading taken before the start of the billing period.

67 - Peritoneal Dialysis - The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report amount in whole units right-justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)

68 - Erythropoietin Units - Code indicates the number of units of administered EPO relating to the billing period and reported in whole units to the left of the dollar/cents delimiter. NOTE: The total amount of EPO injected during the billing period is reported. If there were 12 doses injected, the sum of the units administered for the 12 doses is reported as the value to the left of the dollar/cents delimiter.

71 - Funding of ESRD Networks - Code indicates the amount of Medicare payment reduction to help fund the ESRD networks. This amount is calculated by the FI and forwarded to CWF. (See §120 for discussion of ESRD networks).

A8 – Weight of Patient – Code indicates the weight of the patient in kilograms. The weight of the patient should be measured after the last dialysis session of the month.

A9 – Height of Patient – Code indicates the height of the patient in centimeters. The height of the patient should be measured during the last dialysis session of the month. This height is as the patient presents.

FL 42 - Revenue Codes

The revenue code for the appropriate treatment modality under the composite rate is billed (e.g., 0821 for hemodialysis). Services included in the composite rate and related charges must not be shown on the bill separately. Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

082X - Hemodialysis - Outpatient or Home Dialysis - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

0 - General Classification	HEMO/OP OR HOME
1 - Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

083X - Peritoneal Dialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by instilling a special solution into the abdomen using the peritoneal membrane as a filter.

0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 -Other Peritoneal Dialysis	PERTNL/HOME/OTHER

084X - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE

2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance 100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 -Other CAPD Dialysis	CAPD/HOME/OTHER

085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient. - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 -Other CCPD Dialysis	CCPD/HOME/OTHER

088X – Miscellaneous Dialysis – Charges for Dialysis services not identified elsewhere.

0 - General Classification	DAILY/MISC
1 – Ultrafiltration	DAILY/ULTRAFILT
2 – Home dialysis aid visit	HOME DIALYSIS AID VISIT
9 -Other misc Dialysis	DAILY/MISC/OTHER

FL 44 - HCPCS/Rates

When a revenue code in the 083x series (peritoneal dialysis) is placed in FL 42, an entry must also appear in FL 44. This entry identifies the duration (number of hours) of the peritoneal treatments. Peritoneal dialysis is usually done in sessions of 10-24 hours duration 7 days a week, and each session is billed and paid as one treatment. Providers enter the number of hours for each session in Value Code 67. They also enter the number of sessions (treatments) in FL 46.

Peritoneal dialysis sessions of between 20-29 hours duration is paid as 1 1/2 treatments. However, for purposes of billing, fractions or decimals are not acceptable. The number of treatments is rounded upwards, e.g., 1 1/2 treatments are equal to 2. The total number of treatments is placed in FL 46. The number of hours for each treatment is entered in FL 44 so that proper payment may be made.

Extended peritoneal dialysis sessions of 30 hours or more, given once a week, in place of 2 or 3 sessions of shorter duration are billed and paid as three treatments. Providers enter the number of hours for each session in FL 44. They also enter the number of treatments in FL 46.

Modifiers are required for ESRD Billing for Adequacy of Hemodialysis. ESRD facilities should report information about the range of urea reduction ratio (URR) values through the use of a G modifier attached to the CPT code 90999 in FL 44 of the UB-92. The CPT code and modifier are required for dialysis reported through UB-92 revenue codes 0820, 0821, and 0829.

G1	Most recent URR of less than 60%
G2	Most recent URR of 60% to 64%
G3	Most recent URR of 65% to 69.9%
G4	Most recent URR of 70% to 74.9%
G5	Most recent URR of 75% or greater
G6	ERSD patient for whom less than seven dialysis sessions have been provided in a month

FL 46 - Units of Service

Hospital-based and independent renal facilities must complete this item. The entries quantify services by revenue category, e.g., number of dialysis treatments. Units are defined as follows:

0634 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of less than 10,000 units of EPO was administered.

0635 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of 10,000 units or more of EPO was administered.

082X - (Hemodialysis) - Sessions

083X - (Peritoneal) - Sessions

084X - (CAPD) - Days covered by the bill

085X - (CCPD) - Days covered by the bill

FL 47 - Total Charges

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities show their customary charges that correspond to the appropriate revenue code in FL 42. They must not enter their composite or the EPO rate as their charge. Independent facilities may enter their composite and/or EPO rates.

Neither revenue codes nor charges for services included in the composite rate may be billed separately (see §90.3 for a description). Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

The last revenue code entered in FL 42 as 000l represents the total of all charges billed.

FL 67 – Principal Diagnosis Code

Hospital-based and independent renal facilities must complete this item and it should include a diagnosis of end stage renal disease.